

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16615

State File No.

Registrar's No.

MAY 27 1943

Registration District No. 318

Primary Registration District No. 10

4491

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... 2 days
 In this community..... Life (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME..... Elizabeth Smith

3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex..... female 5. Color or race..... 3 negro
 6. (a) Single, widowed, married, divorced..... 0
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... Aug 13 1870
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 9 29 hr. min.

9. Birthplace..... Unk. Mo. 1
 (City, town, or county) (State or foreign country)

10. Usual occupation..... Nat

11. Industry or business.....

12. Name..... Unk13. Birthplace..... Unk 9
 (City, town, or county) (State or foreign country)14. Maiden name..... Unk15. Birthplace..... Unk 9
 (City, town, or county) (State or foreign country)16. (a) Informant..... Lucille Troupe(b) Address..... 2212 Eugenia St17. (a) Burial, cremation, or removal..... Burial (b) Date thereof..... May 15 1943
 (Month) (Day) (Year)(c) Place: burial or cremation..... Kansas City, Mo18. (a) Signature of funeral director..... English Ind. Co(b) Address..... 2931 Lutgus, ave19. (a) MAY 14 1943 (b) J. F. Brudick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....
 (c) City or town..... St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No..... 2212 Eugenia
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12,
 year 1943 hour 7 minute 50 P.A.M.

21. I hereby certify that I attended the deceased from May
10, 1943, to May 12, 1943;
 that I last saw h. er alive on May 12, 1943;
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Arterial Hypertension and Arteriosclerosis

Duration

Unknown

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?..... (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)
 (e) Means of injury.....

23. Signature..... J. E. Smith (M. D. or other)
 Address..... 2601 Whittier Date signed..... 5/4/43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

working under my personal supervision.

Registered Apprentice No.....

Signed.....

William English

Licensed Embalmer No. *4208*

P. O. Address *2931 Lucas, Ave*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 16615-
Registrar's No. 4491Registration District No. 318Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County.....St. Louis
(b) City or town.....St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT
FULL NAMEElizabeth Smith3. (b) If veteran,
name war.....3. (c) Social Security
No.....4. Sex F5. Color or
race B6. (a) Single, widowed, married,
divorced Single

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
alive..... years

7. Birth date of deceased.....

Aug 18
(Month) (Day) (Year)18
(Day) (Year)18
(Year)

8. AGE:

Years

Months

Days

If less than one day

72910

min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a).....

(Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a).....

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1943 hour..... minute..... M.21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....
Duration.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)
(e) Means of injury.....23. Signature..... (M. D. or other).....
Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

